BOSTON SENSORY SOLUTIONS

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AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION FOR

_____ _____
Patient Name Date of Birth

I, _____, hereby authorize the Boston Sensory Solutions administrative/ clinical staff to obtain or disclose the following information regarding above named patient. Please check all that apply.

____Confirmation of participation in occupational therapy
____Treatment progress updates/ summary
____OT testing results
____Summary of OT evaluation findings
____On-going consultation
____Professional Collaboration

This information is to be released for purpose of the patient's optimal evaluation, treatment planning, and coordination of services between Boston Sensory Solutions and

_____ .

This authorization shall remain in effect until such time as the patient terminates services with either provider included in this consent or one year from date consent is signed, whichever comes first. Consent may be revoked in writing at any time. This information should only be released to or obtained from:

_____ _____
Name Phone

_____
Address

_____
FAX or Email

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. Revocation will not impact professional communications or exchange of information completed prior to date of revocation.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Parent/ Guardian Date